

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0044131</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Colonial Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>3900 Stearns Ave.</u> <u>Granite City</u> <u>62040</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Madison</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) <u>Scott Lundy</u> (Title) <u>Vice President</u>	
<b>Telephone Number:</b> <u>(618) 931-3900</u> <b>Fax #</b> <u>(618) 931-8147</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) <u>Ken Marx, CPA</u> <u>Partner</u> (Firm Name & Address) <u>BKD, LLP</u> <u>501 N. Broadway, Suite 600, St. Louis 63102</u> (Telephone) <u>314-231-5544</u> <b>Fax #</b> <u>314-231-9731</u>	
<b>IDPA ID Number:</b> <u>37-0958249001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone #</b> (217) 782-1630	
<b>Date of Initial License for Current Owners:</b> <u>October 1973</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Ken Marx</u> <b>Telephone Number:</b> <u>(314) 231-5544</u>			

## STATE OF ILLINOIS

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Facility Name & ID Number Colonial Care Center# 0044131 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>30</u>	Skilled (SNF)	<u>28</u>	<u>10,220</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>92</u>	Intermediate (ICF)	<u>94</u>	<u>34,310</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>122</u>	TOTALS	<u>122</u>	<u>44,530</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>0</u>		<u>4,504</u>	<u>4,504</u>	8
9	SNF/PED					9
10	ICF	<u>24,512</u>	<u>9,158</u>		<u>33,670</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,512</u>	<u>9,158</u>	<u>4,504</u>	<u>38,174</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 85.73%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started October 1973

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 28 and days of care provided 4,504Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Colonial Care Center

# 0044131

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	125,388	22,848	7,513	155,749		155,749		155,749		1
2	Food Purchase		137,870		137,870		137,870		137,870		2
3	Housekeeping		213	120,960	121,173		121,173		121,173		3
4	Laundry			55,489	55,489		55,489		55,489		4
5	Heat and Other Utilities			86,168	86,168		86,168		86,168		5
6	Maintenance	40,520	6,949	36,522	83,991		83,991		83,991		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	165,908	167,880	306,652	640,440		640,440		640,440		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,800	9,800		9,800		9,800		9
10	Nursing and Medical Records	1,452,663	56,111	2,617	1,511,391		1,511,391		1,511,391		10
10a	Therapy	2,334	2,197	430,599	435,130		435,130		435,130		10a
11	Activities	47,584	1,057	2,218	50,859		50,859		50,859		11
12	Social Services	31,278			31,278		31,278		31,278		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,533,859	59,365	445,234	2,038,458		2,038,458		2,038,458		16
	<b>C. General Administration</b>										
17	Administrative	49,312		223,760	273,072		273,072	137,574	410,646		17
18	Directors Fees										18
19	Professional Services			4,030	4,030		4,030		4,030		19
20	Dues, Fees, Subscriptions & Promotions			13,273	13,273		13,273	(7,922)	5,351		20
21	Clerical & General Office Expenses	78,448	13,170	84,247	175,865		175,865	(70,550)	105,315		21
22	Employee Benefits & Payroll Taxes			319,818	319,818		319,818		319,818		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,393	1,393		1,393		1,393		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			53,509	53,509		53,509		53,509		26
27	Other (specify):* <b>Miscellaneous</b>			539	539		539		539		27
28	<b>TOTAL General Administration</b>	127,760	13,170	700,569	841,499		841,499	59,102	900,601		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,827,527	240,415	1,452,455	3,520,397		3,520,397	59,102	3,579,499		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name &amp; ID Number Colonial Care Center

#0044131

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			11,650	11,650		11,650		11,650			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			545	545		545		545			32
33	Real Estate Taxes			54,864	54,864		54,864		54,864			33
34	Rent-Facility & Grounds			844,312	844,312		844,312		844,312			34
35	Rent-Equipment & Vehicles			12,144	12,144		12,144		12,144			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			923,515	923,515		923,515		923,515			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		142,841	8,736	151,577		151,577		151,577			39
40	Barber and Beauty Shops			110	110		110		110			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,637	67,637		67,637		67,637			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		142,841	76,483	219,324		219,324		219,324			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,827,527	383,256	2,452,453	4,663,236		4,663,236	59,102	4,722,338			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Colonial Care Center

# 0044131

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(4,422)	20		17
18	Fines and Penalties	(3,500)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(70,550)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (78,472)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	137,574		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 137,574		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ 59,102		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Colonial Care Center

ID# 0044131

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	\$		1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

12/31/2003

[illegible]



Facility Name & ID Number Colonial Care Center # 0044131 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Cathedral Rock Corporation	100	See Attached		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	\$ 223,760	Cathedral Rock Corp	100.00%	\$ 361,334	\$ 137,574	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 223,760			\$ 361,334	\$ * 137,574	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Colonial Care Center # 0044131 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Colonial Care Center # 0044131 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Cathedral Rock Corp.  
 Street Address 306 West 7th Street  
 City / State / Zip Code Fort Worth, TX 76102  
 Phone Number ( 817 ) 335-4111  
 Fax Number ( 817 ) 335-0800

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	A & G	Total Cost	75,158,771	17	\$ 5,823,730	\$ 4,663,240	\$ 361,334	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,823,730	\$		\$ 361,334	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1							\$				\$	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$				\$	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$				\$	14							
15	TOTALS (line 9+line14)						\$				\$	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ N/A      Line #           

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Colonial Care Center**# **0044131** Report Period Beginning: **01/01/2003** Ending: **12/31/2003****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$ <b>53,898</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ <b>71,689</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>17,791</b>	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>37,073</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>54,864</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998 <b>44,706</b>	8	
	1999 <b>41,785</b>	9	
	2000 <b>47,020</b>	10	
	2001 <b>46,932</b>	11	
	2002 <b>54,864</b>	12	
		<b>FOR OHF USE ONLY</b>	
		13 FROM R. E. TAX STATEMENT FOR 2002 \$	13
		14 PLUS APPEAL COST FROM LINE 5 \$	14
		15 LESS REFUND FROM LINE 6 \$	15
		16 AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME Colonial Care Center COUNTY Madison  
FACILITY IDPH LICENSE NUMBER 0044131  
CONTACT PERSON REGARDING THIS REPORT Ken Marx  
TELEPHONE ( 314 ) 231-5544 FAX #: ( 314 ) 231-9731

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

### B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,012

B. General Construction Type: Exterior Masonry Frame Steel Reinforcement

Number of Stories 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALL UNIT			1999	528	106	5	106		458	9
10	WATER HEATER			1999	4,268	854	5	854		3,699	10
11	AUTOSCRUBBER			2002	2,900	580	5	580		1,112	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,696	\$ 1,540		\$ 1,540	\$	\$ 5,269	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 47,293	\$ 9,530	\$ 9,530	\$		\$ 27,933	71
72	Current Year Purchases	9,753	581	581			581	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 57,046	\$ 10,111	\$ 10,111	\$		\$ 28,514	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 64,742	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 11,651	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,651	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 33,783	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Health Care REIT

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1973</u>	<u>122</u>	<u>1/99</u>	\$ <u>844,312</u>	<u>10</u>	<u>20</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>122</u>		\$ <u>844,312</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

N/A

N/A

9. Option to Buy: ☐ YES ☒ NO Terms: \_\_\_\_\_ \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning 01/99

Ending 12/09

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/2004 \$ 844,312

13. 12/31/2005 \$ 844,312

14. 12/31/2006 \$ 844,312

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

D. NUMBER OF AIDES TRAINED

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10, 3	hrs	\$	2,899	\$ 207,397	\$	2,899	\$ 207,397	1
2	Licensed Speech and Language Development Therapist	10, 3	hrs		182	13,415		182	13,415	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10, 3	hrs		4,351	209,787	2,197	4,351	211,984	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	7,432	\$ 430,599	\$ 2,197	7,432	\$ 432,796	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Colonial Care Center

# 0044131

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (160,267)	\$	1
2	Cash-Patient Deposits	27,731		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 194,894 )	781,214		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Utility Deposits</u>	8,604		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 657,282	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	7,696		15
16	Equipment, at Historical Cost	60,046		16
17	Accumulated Depreciation (book methods)	(33,782)		17
18	Deferred Charges	6,200		18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 40,160	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 697,442	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 312,205	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,541		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	64,312		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Other accrued expenses</u>	108,469		36
37	<u>Unearned revenue</u>	137,222		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 635,750	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	77,216		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Deferred gain on lease</u>	145,523		43
44	<u>Payable to related parties</u>	144,202		44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 366,941	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,002,691	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (305,249)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 697,442	\$	48

\*(See instructions.)

## XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (111,899)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (111,899)	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(193,350)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (193,350)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (305,249)	24 *

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,518,597	1
2	Discounts and Allowances for all Levels	(2,060,923)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,457,674	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	718,265	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 718,265	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	811	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	815	16
17	Sale of Drugs	219,993	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	64,573	19
20	Radiology and X-Ray	6,565	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 292,757	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	88	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 88	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Vending machine income	500	28
28a	Miscellaneous income	602	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,102	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,469,886	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	640,440	31
32	Health Care	2,038,458	32
33	General Administration	841,499	33
	<b>B. Capital Expense</b>		
34	Ownership	923,515	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	219,324	35
36	Provider Participation Fee		36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,663,236	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(193,350)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (193,350)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name &amp; ID Number Colonial Care Center

# 0044131

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1 Director of Nursing	2,151	2,151	\$ 58,737	\$ 27.31	1
2 Assistant Director of Nursing	2,305	2,305	52,858	22.93	2
3 Registered Nurses	8,414	8,989	186,821	20.78	3
4 Licensed Practical Nurses	27,313	28,632	454,501	15.87	4
5 Nurse Aides & Orderlies	82,485	86,368	666,400	7.72	5
6 Nurse Aide Trainees					6
7 Licensed Therapist					7
8 Rehab/Therapy Aides	276	276	2,334	8.46	8
9 Activity Director					9
10 Activity Assistants	5,124	5,210	47,584	9.13	10
11 Social Service Workers	2,887	3,015	31,278	10.37	11
12 Dietician					12
13 Food Service Supervisor					13
14 Head Cook					14
15 Cook Helpers/Assistants	17,110	17,659	125,389	7.10	15
16 Dishwashers					16
17 Maintenance Workers	3,535	3,648	40,520	11.11	17
18 Housekeepers					18
19 Laundry					19
20 Administrator	2,543	2,543	49,312	19.39	20
21 Assistant Administrator					21
22 Other Administrative	7,095	7,775	78,448	10.09	22
23 Office Manager					23
24 Clerical					24
25 Vocational Instruction					25
26 Academic Instruction					26
27 Medical Director					27
28 Qualified MR Prof. (QMRP)					28
29 Resident Services Coordinator					29
30 Habilitation Aides (DD Homes)					30
31 Medical Records	2,850	3,074	33,345	10.85	31
32 Other Health Care(specify)					32
33 Other(specify)					33
34 TOTAL (lines 1 - 33)	164,088	171,645	\$ 1,827,527 *	\$ 10.65	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35 Dietary Consultant	190	\$ 7,513	1, 3	35
36 Medical Director	212	9,800	9, 3	36
37 Medical Records Consultant	4	305	10, 3	37
38 Nurse Consultant				38
39 Pharmacist Consultant				39
40 Physical Therapy Consultant	446	4,528	39, 3	40
41 Occupational Therapy Consultant				41
42 Respiratory Therapy Consultant				42
43 Speech Therapy Consultant				43
44 Activity Consultant				44
45 Social Service Consultant				45
46 Other(specify)				46
47				47
48				48
49 TOTAL (lines 35 - 48)	852	\$ 22,146		49

## C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50 Registered Nurses		\$		50
51 Licensed Practical Nurses				51
52 Nurse Aides				52
53 TOTAL (lines 50 - 52)		\$		53

Facility Name &amp; ID Number Colonial Care Center

# 0044131

Report Period Beginning: 01/01/2003

**Ending: 12/31/2003**

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Tracy Henry	Administrator	NONE	\$ 49,312	Workers' Compensation Insurance		\$ 113,961	IDPH License Fee		\$		
				Unemployment Compensation Insurance		8,410	Advertising: Employee Recruitment		4,421		
				FICA Taxes		141,051	Health Care Worker Background Check (Indicate # of checks performed _____)				
				Employee Health Insurance		48,464	Bank Fees		902		
				Employee Meals			License & Fees		3,673		
				Illinois Municipal Retirement Fund (IMRF)*			Fines & Penalties		3,500		
				Benefits		93	Medicare Expense		312		
				Bonus		1,025	Dues & Subscriptions		465		
				401 (k)		6,814					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 49,312				Less: Public Relations Expense	(			
B. Administrative - Other							Non-allowable advertising		(7,922)		
							Yellow page advertising	(			
Description			Amount								
Management Fee			\$ 223,760								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 223,760	TOTAL (agree to Schedule V, line 22, col.8)			\$ 319,818	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 5,351	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
Accounting	Various		\$ 4,030			\$	Out-of-State Travel		\$		

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

Facility Name & ID Number Colonial Care Center

STATE OF ILLINOIS

# 0044131

Report Period Beginning:

01/01/2003

Ending:

Page 23

12/31/2003

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. No
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,542 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 67,637  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.